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No. 97-218

In The

Supreme Court of the United States

October Term, 1997

STEVEN B. LARSEN, in his capacity as Insurance Commisssioner of the State of Maryland,

Petitioner,

vs.

AMERICAN MEDICAL SECURITY, INC., *et al.*,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

SUPPLEMENTAL BRIEF FOR RESPONDENTS

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This case presents the question of whether a state regulation that is intended to prevent small employers from forming self-funded employee welfare benefit plans is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). In their Brief in Opposition, Respondents demonstrated that the preemption issues presented by this case are of great public importance and that this Court should issue its Writ in order to affirm the holding of the United States Court of Appeals for the Fourth Circuit.

On May 29, 1998, in response to this Court's invitation, the United States filed its Brief for the United States as *Amicus Curiae*. Although the United States concludes that the court of appeals may have erred, it cautions against review. First, the United States suggests that there is merely a tension, and not an actual conflict, among the circuits on the issues presented by this case. Second, the United States contends that there is a state law question regarding the operation of the state regulation that bears on the preemption issue, but which was not sufficiently developed below. Because the views articulated by the United States are premised on certain fundamental inaccuracies, Respondents submit this Supplemental Brief.

I.

THIS COURT SHOULD ISSUE ITS WRIT TO CLARIFY AND STABILIZE A CRUCIAL AREA OF ERISA LAW.

Respondents do not disagree with the United States' analysis of the tension that exists among the circuits with respect to the issues raised by this case. Respondents disagree, however, that that militates against this Court's review of those issues. While there may be only tension among the circuits, there is clear conflict between the states and the circuits. At the time that the Petition was filed, 16 states in addition to Maryland regulated attachment points for stop loss insurance polices issued to employee welfare benefit

plans. The minimum attachment points set by those states vary from the Maryland regulation and from one another.[1]

This conflict in the actual regulation of attachment points has led to confusion in an industry that affects millions of employees. That confusion must be resolved by this Court. If self-funded plans cannot cede what they deem to be excess risk without being forced to adopt the benefit structure decreed by the state, self-funding will no longer be a viable option for many employers.

II.

DEVELOPING MECHANISMS TO ELIMINATE SELF-FUNDED ERISA PLANS IS NOT THE REGULATION OF THE BUSINESS OF INSURANCE.

The United States identifies the critical statutory inquiry in this case as "whether petitioner's regulation 'regulates insurance (without, for that purpose, 'deem[ing]' any plan 'to be an insurance company')." Brief for United States at 9. Although it answers that inquiry in the affirmative, the United States fails to articulate the factors to be considered in assessing whether state action is the regulation of insurance and ignores the court of appeals' articulation and application of those factors.

The United States' position is wrong, because it ignores the fact that the express goal of petitioner's regulation is to eliminate

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1. In *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708 (2nd Cir. 1993), *rev'd on other grounds*, 514 U.S. 645 (1994), the Second Circuit concluded that ERISA preempted an actuarial letter issued by the New York Department of Insurance that purported to regulate the terms of stop loss insurance contracts, because the regulation required the stop loss carrier to, among other things, include certain mandated coverages. The Second Circuit found that such a regulation was merely a pretext to regulate the terms of self-funded ERISA plans and, therefore, was not saved as the regulation of insurance. *Id.* at 724. This Court declined consideration of that holding in that case. This case (and the patchwork of state legislation in this area) demonstrates, however, that the question is a reoccurring one that both requires and merits this Court's consideration.

self-funding by certain employers by forcing the plan to accept more risk than prudent management would dictate. As the court of appeals correctly concluded, the elimination of self-funded benefit plans is not the regulation of insurance, regardless of the mechanism employed to accomplish it and, thus, the regulation is not saved.

The savings clause preserves from preemption any state law "which regulates insurance, banking or securities." 29 U.S.C. § 1144(b)(2)(A). In determining whether a state law is saved by the savings clause, this Court has adopted a conjunctive, two-step approach. First, the regulation must fall within the "common sense" definition of insurance. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740-41 (1985). Second, the regulation must meet the three prong test adopted in interpreting the McCarran-Ferguson Act. *Id.* at 743.[2]

The court of appeals correctly concluded that the Maryland regulation is not the regulation of insurance, because it merely uses the regulation of "stop loss insurance policies as a vehicle to impose the requirements of Maryland health insurance law on self-funded ERISA plans." Pet. App. 12a. As Judge Niemeyer reasoned:

> In this case, the Maryland Insurance Comissioner can well argue with respect to the first *Metropolitan Life* factor that the setting of attachment points allocates

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2. As Judge Niemeyer stated:

> In determining whether a state law is one that "regulates insurance" it is not enough that it operate only on insurance companies or insurance policies. The regulation must regulate the business of insurance in the sense that the object of its regulation (1) "has the effect of transferring or spreading a policyholder's risk"; (2) "is an integral part of the policy relationship between the insurer and the insured"; and (3) "is limited to entities within the insurance industry."

Pet. App. 10a (quoting *Metropolitan Life*, 471 U.S. at 743).

plans. The minimum attachment points set by those states vary from the Maryland regulation and from one another.[1]

This conflict in the actual regulation of attachment points has led to confusion in an industry that affects millions of employees. That confusion must be resolved by this Court. If self-funded plans cannot cede what they deem to be excess risk without being forced to adopt the benefit structure decreed by the state, self-funding will no longer be a viable option for many employers.

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> insurance and its coverage of risks, but with the benefits that ERISA plans can choose to provide their participants and beneficiaries. No matter how understandable this concern may be, only Congress may address it, not the State of Maryland through its insurance regulations.

Pet. App. 12a.

The United States also accepts the fundamentally erroneous proposition that stop loss insurance with low attachment points is the equivalent of group health insurance and that benefit plans that purchase stop loss insurance are not truly self-funded. This is particularly disturbing given that the Department of Labor ("DOL"), in its advisory opinions, has consistently taken the position that a contract of stop loss insurance is not group health insurance and that ceding even 100% of the risk does not necessarily convert a self-funded benefit plan into a fully insured plan.

Pursuant to amendments adopted by Congress in 1983, an employee welfare benefit plan that is a multiple employer welfare arrangement ("MEWA") may be regulated by the states. If the MEWA is fully insured, there is no limitation as to the scope of the state's regulatory authority. If, however, the MEWA is not fully insured, the state regulation is limited to state laws that are not inconsistent with ERISA. 29 U.S.C. § 1144(b)(6)(A)(ii).

A MEWA is considered to be fully insured only if "all" of the benefits provided "are guaranteed under a contract, or policy of insurance . . ." 29 U.S.C. § 1144(b)(6)(D). DOL has consistently taken the position that "[t]he fact that [a MEWA] may have obtained stop loss insurance does not in itself indicate that the Trust is fully insured within the meaning of [29 U.S.C. § 1144(b)(6)(D)]." ERISA Advisory Opinion 90-48A; *see also* ERISA Advisory Opinion 91-05A.[3] A stop loss insurance policy is only considered

3. All advisory opinions referred to herein have been lodged with the Court.

to be fully insured "if the terms of the arrangement provide that the amount of *all* benefits are guaranteed under the insurance contract or policy." ERISA Advisory Opinion 91-05A (emphasis added).

In response to an inquiry from the Commissioner of Insurance for the State of Connecticut, the Director of Regulations and Interpretations at the Pension and Welfare Benefit Administration of DOL issued an advisory opinion on whether a MEWA that intended to cede or secure guarantees covering 100% of its assumed risk was fully insured. ERISA Advisory Opinion 94-07A. A non-profit trade association of small employers consolidated seven trusts into a single Trust, which received contributions from participating employers and paid claims to employee beneficiaries. The Trust entered into a " 'quota share reinsurance agreement' " with National Health Insurance Company ("NHIC") through which NHIC agreed to "pay to the Trust 90% of the liabilities that the Trust incurs under its benefit plan, up to a per-claim limit of $10 million" and to "guarantee[ ] payment to the Trust of the Trust's retained portion of the liabilities in the event the Trust is unable to fund that portion." *Id.* at 5. DOL found that the agreement between NHIC and the Trust would not cause the Trust to be fully insured, primarily because plan participants would "be required to present benefit claims to the Trust, and benefit payments would be made solely by or on behalf of the Trust." *Id.* at 6.

This is precisely the reasoning employed by the court of appeals in rejecting petitioner's suggestion that stop loss insurance is the functional equivalent of group health insurance. The court noted that

> Under a self-funded plan, the employer who promises the benefit incurs the liability defined by the plan's terms. That liability remains the employer's even if the stop loss insurer becomes insolvent. Conversely, if the employer becomes insolvent, the solvency of the stop loss insurer may not benefit plan participants

> and beneficiaries * * * . In contrast, when a plan buys health insurance for participants and beneficiaries, the plan participants and beneficiaries have a legal claim directly against the insurance company, thereby securing the benefits in the event of the plan's solvency * * * .

Pet. App. 13a.

In short, as the court of appeals correctly recognized, a state regulation which is promulgated for the express purpose of forcing certain self-funded plans to abandon self-funding does not regulate insurance and is not saved from preemption. The Brief of the United States as *Amicus Curiae* ignores this fundamental point and, thus, adopts a position that is fundamentally wrong.

III.

THE MARYLAND REGULATION UNAMBIGUOUSLY CONVERTS STOP LOSS INSURANCE INTO GROUP HEALTH INSURANCE.

The United States concedes that a

> regulation that purported to rearrange existing contractual relationships among plans, their participants, and plan insurers, even as a remedy for violation of an otherwise valid insurance regulation * * * might well be preempted by ERISA.

Brief of the United States at 19. That is precisely what the Maryland regulation does. Nonetheless, the United States contends that this case is not an appropriate vehicle to address this issue, because, it claims: (a) petitioner has disavowed "any intention to convert policies issued as 'stop loss' coverage into group health policies by operation of state law . . . ."; (b) the United States perceives an ambiguity as to whether the regulation would effectively convert

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The regulation clearly intends to treat as group health insurance stop loss policies that are issued with attachment points below the stated minimum. There can be no good faith argument that the consequence of labeling a stop loss policy a group health policy is anything other than to require an employer to provide mandated benefits. The Maryland Insurance Code states:

> An otherwise valid insurance policy, rider, or endorsement issued after December 31, 1963, with a condition or provision that does not comply with the requirements of this article is not invalid but is to be construed and applied in accordance with the condition or provision that would be applicable if the policy, rider, or endorsement were in full compliance with this article.

Md. Code Ann., Ins. Art. § 12-103.

Notwithstanding whatever private disavowals petitioner may have made to the United States, the regulation, on its face, clearly and unambiguously converts into group health insurance any stop loss policy that does not meet the statutory criteria. That aspect of the regulation's operation was one of the bases on which the court of appeals concluded that the regulation was preempted and there is no impediment to this Court's consideration of the regulation or its operation.

CONCLUSION

This case squarely presents questions left open by *Metropolitan Life* and its progeny and is the perfect vehicle by which to clarify that state action that intentionally or effectively forces an employee benefit plan to adopt a particular benefit structure or to terminate is preempted by ERISA.[4] For the reasons set forth herein, and in Respondents' Brief in Opposition, this Court should grant the Petition.

Respectfully submitted,

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4. This is precisely the issue that Mr. Justice Souter seemed to invite, albeit at a different point in the ERISA preemption analysis, when he noted in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers, Inc.*, 514 U.S. 645, 668 (1995):

> We acknowledge that a state law might produce such acute, albeit indirect economic effects, by intent or otherwise, as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers, and that such a state law might indeed be preempted under § 514.

APPENDIX

APPENDIX A — STATUTES INVOLVED

29 U.S.C. § 1144

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies,

insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section —

(i) any state tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii

to assist them in effectuating the policies of provisions of such Act which are superseded by such parts.

(6)(A) Notwithstanding any other provision of this section —

> **(i)** in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —
>
> > **(I)** standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and
> >
> > **(II)** provisions to enforce such standards, and
>
> **(ii)** in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted

insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw.Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section —

(i) any state tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii

State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

Appendix A

ANNOTATED CODE OF MARYLAND, INSURANCE ARTICLE § 12-103

§ 12-103. Validity and construction of noncomplying conditions or provisions.

An otherwise valid insurance policy, rider, or endorsement issued after December 31, 1963, with a condition or provision that does not comply with the requirements of this article is not invalid but is to be construed and applied in accordance with the condition or provision that would be applicable if the policy, rider, or endorsement were in full compliance with this article. (An. Code 1957, art. 48A, § 378; 1995, ch. 36.)